STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175151	A. BUILDING _____ B. WING _____	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE MEMORIAL HOSPITAL SNF	325 MAINE ST LAWRENCE, KS 66044

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to	F 156		

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F 156	Continued From page 2 receive refunds for previous payments covered by such benefits. This Requirement is not met as evidenced by: The facility reported a census of 1 resident. Based on observation, record review, and interview the facility failed to provide the appropriate notice of Medicare Non-Coverage, CMS 10123 for 3 (#25, #47, #43) of 3 residents reviewed for liability notices. Findings included: - Record review on 8/28/13 at 10:04 A.M. revealed the facility provided form CMS 10123 to resident #25 dated 3/24/13 which lacked what specific type of Medicare services ended and the date they ended. Interview with social service staff J on 8/28/13 at 10:06 A.M. stated he/she was not aware of the need to place the specific services that ended on the form. The facility failed to identify the medicare services the resident received and the date when the services ended. - Record review on 8/28/13 at 10:04 A.M. revealed the facility provided form CMS 10123 to resident #47 dated 4/23/13 which lacked what type of Medicare services ended. Interview with social service staff J on 8/28/13 at 10:06 A.M. stated he/she was not aware of the need to place the specific services that ended on the form.	F 156		

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F 156	Continued From page 3 The facility failed to identify the medicare services the resident received. - Record review on 8/28/13 at 10:04 A.M. revealed the facility provided form CMS 10123 to resident #43 dated 3/25/13 lacked what specific type of Medicare services ended. Interview with social service staff J on 8/28/13 at 10:06 A.M. stated he/she was not aware of the need to place the specific services that ended on the form. The facility failed to identify the medicare services the resident received.	F 156		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility had a census of 1 resident. The sample included 6 residents. Based upon record review and interviews the facility failed to promote the healing of pressure ulcers that were present for 1 (#40) of 1 residents. Findings included:	F 314		

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- Resident #40's (a closed record) admission Minimum Data Set (MDS) 3.0 dated 5/16/13 identified the resident scored 8 (moderately impaired cognition) on the Brief Interview for Mental status, did not exhibit behaviors, required extensive staff assistance with bed mobility, transfers, walking in the corridor, locomotion on the unit, dressing, toilet use, and personal hygiene. The MDS coded the resident required limited staff assistance with eating and was totally dependent upon staff for locomotion off the unit. The MDS recorded the resident was always continent, of urine, had a diagnosis of cancer, weighed 169 pounds and had not experienced a weight loss. The MDS identified the resident had (1) Stage 2 pressure ulcer present upon admission, and (1) unstageable pressure ulcer with suspected deep tissue injury in evolution present upon admission. The MDS coded the resident had a pressure reducing device on his/her bed, was on a turning/repositioning program, received nutrition or hydration interventions, pressure ulcer care, and application of ointments/medications.

The resident's Nutritional Status Care Area Assessment (CAA) dated 5/16/13 documented the resident had an advanced cancer diagnosis which negatively affected his/her oral intake, and received a nutritional supplement with all meals.

The resident Pressure Ulcer CAA dated 5/16/13 documented the resident had a pressure ulcer on his/her coccyx which was present on admission, staff routinely repositioned the resident, the resident had an air bed, staff routinely monitored the resident's pressure ulcer and the pressure ulcer dressing was changed to barrier cream.

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The resident scored 18 (mild risk) on the Braden Scale (scale used to predict the development of pressure ulcers) on 5/3/13.

The resident's care plan dated 5/4/13 addressed the resident had skin breakdown, and staff implemented standard skin care/breakdown prevention interventions. The care plan included staff repositioned the resident at least every 2 hours, used a lift sheet with repositioning, staff elevated the resident's edematous areas, staff offloaded the resident's potential pressure areas with pillows/other positioning devices, and the resident utilized elbow protectors, and heel protectors. The care plan included staff applied a protective barrier cream, inspected the resident's pressure points at least twice daily, and applied a wound dressing. An interdisciplinary nursing note included on the care plan, documented the resident had a Stage 2 pressure area on his/her coccyx, staff applied Duoderm (a wound care dressing), the resident had a suspected deep tissue injury to his/her left heel, and wore heel protectors when in bed.

A physician's order dated 5/4/13 and timed 9:00 A.M. included for staff to apply Duoderm to the Stage 2 pressure ulcer on the resident's coccyx and change every 3 days and as needed.

Review of the resident's physician's orders revealed staff renewed the physician's order for the Duoderm every 3 days.

A Registered Dietician (RD) note dated 5/6/13 and timed 12:54 P.M. documented staff provided the resident Ensure Plus (a nutritionally supplement that provided additional calories and protein) with each meal.

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A RD note dated 5/13/13 and timed 9:22 A.M. revealed staff continued to provide the Ensure Plus and snacks.

A RD note dated 5/20/13 and timed 1:16 P.M. documented the resident consumed more of the Ensure if staff added ice cream to it, therefore the resident would receive Ensure Plus shakes with lunch and dinner, and the resident had Ensure in his/her room that staff could mix with ice cream if the resident did not eat well at breakfast.

A RD note dated 5/24/13 and timed 12:43 P.M. documented the resident continued to receive the Ensure shake at lunch and dinner.

A laboratory report dated 5/16/13 and timed 2:05 P.M. recorded the resident's serum albumin (indicator of protein) at 3.0 grams/deciliter (normal reference range 3.5 to 5.7 grams/deciliter).

Review of the resident' skin assessment revealed the following:

5/3/13: The Stage 2 pressure ulcer on the resident's coccyx measured 0.5 centimeters (cm) by 0.5 cm

5/13/13: The Stage 2 pressure ulcer on the resident's coccyx measured, 0.8 cm by 0.1 cm, had a scant amount of sanguineous drainage, the surrounding tissue was blanchable and maroon/purple in color, and the pressure ulcer had deteriorated, and staff continued with the Duoderm dressing.

There were no measurements from 5/3/13 to 5/13/13 (duration of 10 days).

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5/17/13: The Stage 2 pressure ulcer on the resident's coccyx measured 1 cm by 1 cm and the facility continued with the Duoderm dressing.

There were no measurements from 5/17/13 to 5/28/13 (the date the facility discharged the resident).

The clinical record did not support the facility revaluated the pressure ulcer treatment after the pressure ulcer on the resident's coccyx became worse.

Review of the resident's left heel skin assessment revealed the following:

5/3/13: The suspected deep tissue injury (SDTI) pressure ulcer measured 0.5 cm by 0.5 cm

5/13/13: SDTI pressure ulcer measured measured 1.5 cm by 0.6 cm

5/17/13: The SDTI pressure ulcer measured 1.2 by 0.6 cm

No other measurements were included on the left heel skin assessment prior to the resident's discharge on 5/28/13.

Review of the resident's fluid intake from 3/11/13 to 3/27/13 did not support the facility recorded the percentage of the nutritional supplement the resident received.

On 8/28/13 at approximately 11:45 A.M. administrative nursing staff B stated the facility measured wounds at least once a week, and staff should change the pressure ulcer treatment if pressure ulcers became worse. Administrative nursing staff B confirmed the facility did not

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measure the pressure ulcer on the resident's coccyx or left heel each week. Administrative nursing staff B confirmed the facility did not change the treatment after the pressure ulcer on the resident's coccyx became worse.

On 8/28/13 at 1:20 P.M. licensed staff D stated dietary staff brought all fluids up on the resident's tray including nutritional supplements and staff recorded the percentage of fluids consumed during meals. Licensed nurse D stated the percentage recorded included the nutritional supplement and staff did not separately record the percentage of the supplement.

On 8/28/13 at approximately 1:45 P.M. dietary staff F stated the facility did not separately record the percentage of the nutritionally supplement. Dietary staff F stated the percentage of the supplements was included in oral intake, therefore he/she would not know how many calories/protein the resident received from the supplements. Dietary staff stated the nutritional supplements contained lots of protein and calories and it was a concern that staff did not separately record the percentage of the nutritional supplement the resident consumed. Dietary staff F stated staff offered all residents a snack at bedtime and during the timeframe when the resident resided in the facility the facility did not record the percentage of snacks residents received.

According to the Pressure Ulcer Prevention & Treatment clinical Practice Guideline developed by the National Pressure Ulcer Advisory Panel and the European Pressure Advisory Panel: if progress was not seen toward pressure ulcer healing within 2 weeks, the individual, the pressure ulcer and the plan of care should be

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F 314	Continued From page 9 re-evaluated. Assess the pressure ulcer initially and re-assess at least weekly, documenting findings. Review of the facility's skin breakdown prevention and management protocol dated August 2012 included refer to the Wound Care Management Procedure for more information about measuring/assessing/documenting wounds. The facility did not provide the Wound Care Management Procedure. The facility failed to measure the Stage 2 pressure ulcer on the resident's coccyx and the SDTI on the resident's left heel weekly, and failed to re-evaluate the treatment after the Stage 2 pressure ulcer on the resident's coccyx deteriorated.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility reported a census of 1 resident and the sample was 6 residents. Based on observation, record review, and interview the facility failed to monitor planned interventions and/or failed to follow doctors order related to	F 325		

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nutrition for 2 (#2, #43) of 3 residents reviewed for nutrition.

Findings included:

- Resident #2's closed record revealed a 14 day Minimum Data Set (MDS) 3.0 dated 8/7/13 which recorded the resident with a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had mild cognitive impairment. The MDS recorded the resident required extensive assistance with bed mobility, transfers, dressing, toilet use, eating and personal hygiene. The MDS also indicted the resident was on a mechanically altered diet.

The Care Area Assessment (CAA) dated 8/7/13 for nutrition recorded the resident had poor appetite, and stated nothing tasted good. The resident had some weight loss and the dietician was following him/her.

The care plan dated 8/13/13 stated the resident had a poor appetite and refused alternative food. He/she was observed telling a caregiver he/she was not hungry and to leave him/her alone. Dietary will consult.

Dietary consult on 7/26/13 documented to provide an evening snack providing 300 calories (2 chocolate ice cream containers).

Dietary consult on 7/29/13 documented to provide a high protein shake twice a day.

Dietary consult on 8/6/13 documented to provide chocolate ensure (high calorie supplement) with lunch and dinner, add a half soft sandwich twice a day, give one ice cream at 2:00 P.M., and one high protein shake at 7:00 P.M.

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F 325	Continued From page 11 Dietary consult on 8/8/13 documented to modify the meal plan to include small portions and continue ensure at lunch and dinner. The dietician talked with nursing, to include what the resident did eat rather than the percentage consumed. A physician's order dated 8/8/13 reported an order for a calorie count for the next 3 days. Dietary consult on 8/12/13 documented on 8/9/13 staff documented three meals equaling 1226 calories and 68 grams of protein, on 8/10/13 staff documented two meals equaling 465 calories and 29 grams protein, and on 8/11/13 staff documented one meal equaling 245 calories with 11 grams of protein. The information regarding mea; intake was incomplete. Record review revealed documentation of liquids consumed at meal times included all liquids with the supplements included. Documentation of percentage of supplements taken were noted if not with a meal. The documented weights on 7/25/13 was 198 pounds (lbs), 8/1/13 was 183 lbs., and on 8/8/13 was 185 lbs. Interview with administrative dietary staff F on 8/28/13 at 12:25 P.M. stated this resident had a lot of confusion, staff tried high protein shakes every day and the percentage was documented. At the meals the supplements were included with all other fluids drank. Staff stated the calorie count was not completed by staff as it should have been. It was ordered over the weekend and that should not made a difference but it did. Sometimes he/she had to track down the staff to	F 325		

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get the form to make sure it was completed. When a resident was on calorie count all the staff were informed by the mat under the plate, a sticker on the meal card and a notice on the nursing task list.

Interview with direct care staff C on 8/28/13 at 2:29 P.M. stated the resident did not want to eat very much. When the staff documented fluid intake in the computer they added all the fluids for the meal together even if the resident had a supplement with their meal. When a resident was on a calorie count it was different. The staff needed to write down exactly how many bites the resident ate or how much the resident consumed of each item on the plate. The staff then placed the paper in a special place in the dining room for the dietician to pick up.

Interview with administrative nursing staff A on 8/28/13 at 2:49 P.M. stated this resident had end stage Alzheimers and sometimes would not eat. Staff stated he/she did not remember the resident was on a calorie count but staff were expected to fill out the meal sheet in detail and then place in envelope in dining room. He/she would not expect the nurse to check to make sure that it was completed. The dietician did go to the staff sometimes to get the information that was not provided.

The facility policy dated 08/2013 for nutritional status reported the staff to write the percentage of each item on the slip provided.

The facility lacked evidence of documentation of supplements and calories for this cognitively impaired resident with weight loss.

- Resident #43's (a closed record) admission

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F 325	Continued From page 13 MDS 3.0 dated 3/22/13 identified the resident scored 15 (intact cognition) on the Brief Interview for Mental Status, did not exhibit behaviors, required extensive staff assistance with transfers, walking in the room/corridor, and locomotion on the unit, and required limited staff assistance with eating. The MDS recorded the resident weighed 104 pounds, had not experienced a weight loss of 5 percent (%) or more in the last month or 10% or more in the last 6 months, and had a diagnosis of cancer. The resident's Nutritional Status Care Area Assessment (CAA) dated 3/22/13 documented the resident's oral intake was suboptimal, received a regular diet, the resident's estimated calorie needs were 1250 calories per day, and the resident's nutritional intake had improved since admission. The resident's care plan dated 3/12/13 included the resident's oral intake was suboptimal, and staff encouraged the resident to eat. The care plan included the resident received nutritional supplements, snacks, soft textured foods, and the dietician managed the resident's nutritional needs. A Registered Dietician's (RD) note dated 3/12/13 and timed 11:55 A.M. documented the resident weighed 110 pounds, received a mechanical soft diet with small portions per family request, and the resident's estimated calorie needs were 1200 calories per day. The note included the resident received Ensure (nutritional supplement that provided additional calories and protein) shakes twice a day with lunch and supper which provided 960 calories and 27 grams of protein. A RD note dated 3/13/13 and timed 10:36 A.M.	F 325		

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	175151	A. BUILDING _____ B. WING _____	08/30/2013

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F 325	Continued From page 14	F 325		

documented the resident's intake was very poor, the resident consumed only a few bites at breakfast, and expressed the Ensure was too sweet. The note included the resident continued to receive small portions of a mechanical soft textured diet, staff would offer the resident 4 ounces of Ensure Plus diluted with whole milk with each meal, and staff would continue attempts to acquire the resident's food preferences.

A RD note dated 3/15/13 and timed 7:11 A.M. documented the resident's intake appeared improved, the resident's fluid intake was less than 1 liter per day, he/she discussed the resident's fluid needs with staff and staff would offer the resident additional fluids throughout the day.

A RD note dated 3/21/13 (timed unknown) documented the resident weighed 104 pounds, the resident received a regular diet with Ensure shakes daily, the resident's intake continued to be suboptimal, the resident's estimated calorie needs were only 1250 calories per day, the resident's intake had much improved since the initial nutritional evaluation, staff would continue the current plan, and would continue to monitor the resident.

Review of the resident's weight log revealed the following weights:

3/11/13: 110 pounds (#'s)
3/18/13: 104 #'s (a decrease of 4 #'s or 5.45% in a week)
3/25/13: 103 #'s

Review of the resident's fluid intake from 3/11/13 to 3/27/13 did not support the facility recorded the percentage of the nutritional supplement the

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F 325	Continued From page 15 resident received. Review of the resident's nutrition intake log from 3/11/13 to 3/27/13 revealed the resident consumed 50% or less of meals. The intake log did not support staff offered the resident 's snacks. On 8/28/13 at 1:20 P.M. licensed D nurse stated dietary staff brought all fluids up on resident's tray including nutritional supplements and staff recorded the percentage of fluids consumed during meals. Licensed nurse D stated the percentage recorded included the nutritional supplement and staff did not separately record the percentage of the supplement. On 8/28/13 at approximately 1:45 P.M. dietary staff F stated the facility did not separately record the percentage of the nutritionally supplement. Dietary staff stated F the percentage of the supplements was included in oral intake, therefore he/she would not know how many calories/protein the resident received from the supplements. Dietary staff F stated the nutritional supplements contained lots of protein and calories and it was a concern that staff did not separately record the percentage of the nutritional supplement the resident's consumed. Dietary staff stated staff offered all residents a snack at bedtime and during the timeframe when the resident resided in the facility the facility did not record the percentage of snacks the residents consumed. The facility failed to separately document the percentage of the nutritionally supplement for this resident who had experienced a significant weight loss.	F 325		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 16 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 1 resident. Based on observation and interview in 1 of 1 kitchen on 1 of 2 days onsite of the survey the facility failed to label and date food items when opened. Findings included: - Observation of the kitchen on 8/27/13 at approximately 10:30 A.M. revealed several cut pies with no use by date. Further observation revealed the pies did not have a date indicating when the facility had received and/or cut the pies. Observation also revealed 4 submarine sandwiches in a refrigerator with no date to indicate when the facility prepared the sandwiches. Observation revealed open bags of chicken tenders, popcorn chicken, shrimp, and beef fritters in a freezer without a date to indicate when the facility opened the bags. Observation also revealed (2) metal containers of vegetables in a refrigerator that were not labeled or dated. Dietary staff G at that time stated, open food items should be dated with a use-by date or the date staff opened the bags or prepared the food items.	F 371		

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F 371	Continued From page 17 The facility failed to ensure prepared and open containers of food were dated and labeled to ensure food items were used by the use-by date.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 18 infection. This Requirement is not met as evidenced by: The facility reported a census of 1 resident. Based on observation, record review, and interview the facility failed to track and trend infections. Findings included: - A review of the facility's Infection Control Program from May to August 2013 for the skilled unit lacked information the facility tracked and trended the infections. A report dated 7/2013 listed all the residents alphabetically that had a positive urine culture that month. This report was approximately 10 pages long. The report lacked tracking or trending. Licensed staff H on 8/28/13 at 1:03 P.M. stated he/she received notification of infections and cultures from the lab. At the end of the month he/she placed the infections on a report. Licensed staff H stated he/she filled out the reports for only certain infections. Interview with administrative licensed staff D on 8/28/13 at 1:05 P.M. stated he/she was not under the impression all infections needed tracked. He/she stated they were required to only track serious infections and did not see how they could track and trend every infection. A facility policy dated 10/2010 recorded the Infection Control Preventionist would perform ongoing surveillance for other healthcare	F 441		

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F 441	Continued From page 19 associated infections in order to identify clusters or important trends. The facility failed to have a complete infection control program that tracked and trended infections.	F 441		